

# Authorization for Release of Records



**COLUMBIA GORGE**  
FAMILY MEDICINE

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Hood River, OR 97031

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**IMPORTANT: ALL FORM INFORMATION MUST BE  
COMPLETELY FILLED OUT!**

**Birthdate:** \_\_\_\_\_  
(mm/dd/yyyy)

**Patient Name:** \_\_\_\_\_  
(last name, first name, middle initial)

**Previous Name:** \_\_\_\_\_

For the purposes of:  Transfer of care     Continuing care     Personal     Legal  
 Appointment with \_\_\_\_\_ on \_\_\_\_\_

**I hereby authorize Columbia Gorge Family Medicine to request or release my medical records from or to the organization or individual listed below within the following restrictions:**

To receive records from: \_\_\_\_\_  
Name/Specialty

To send records to: \_\_\_\_\_  
Address

To provide records verbally with: \_\_\_\_\_  
City, State \_\_\_\_\_ Zipcode \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Email \_\_\_\_\_

## Disclosure Restrictions:

### Information to be released:

\_\_\_ All Records for 2 years    \_\_\_ Medical Summary  
\_\_\_ Last Physical Exam/WCC/Diabetic Exam/Sports physical (circle one)  
\_\_\_ Immunizations    \_\_\_ Med List    \_\_\_ EKGs    \_\_\_ PAP/HPV  
\_\_\_ Labs: \_\_\_\_\_  
\_\_\_ Radiology Reports: \_\_\_\_\_  
\_\_\_ Colonoscopy/path/recommendation    \_\_\_ Hospital Admit/Discharge/ER  
\_\_\_ Other \_\_\_\_\_

Oregon law allows you to restrict disclosure of the following types of health information. Check all that apply:

- Mental health records
- Referral for substance abuse:
- Related to HIV/AIDS or STDs

This authorization is valid for 180 days and can be revoked at any time by contacting CGFM's medical records department.

**Signed** \_\_\_\_\_ **by** \_\_\_\_\_  
(mm/dd/yyyy) Signature of patient

**Signed** \_\_\_\_\_ **by** \_\_\_\_\_  
(mm/dd/yyyy) Signature of parent, guardian, or legal representative

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